

Wade-Taxter, Megan (ISDH)

From: Becker, Angela
Sent: Wednesday, September 19, 2018 2:19 PM
To: Wade-Taxter, Megan (ISDH)
Subject: FW: ISDH records request
Attachments: 2017 Clinic for Women.pdf; 2017 PPINKY Bloomington.pdf; 2017 PPINKY Indy.pdf; 2017 PPINKY Lafayette.pdf; 2017 PPINKY Merrillville.pdf; 2017 Women's Med Group.pdf

Categories: Saved to Folder

From: Becker, Angela
Sent: Thursday, June 29, 2017 10:40 AM
To: Humbarger, Cathie <Cathie.Humbarger@Ichooselife.org>
Cc: Snyder, Randall <RSnyder1@isdh.IN.gov>; Becker, Angela <ABecker2@isdh.IN.gov>
Subject: ISDH records request

Good morning Ms. Humbarger.

Pursuant to your request, the Indiana State Department of Health is providing copies of all applications for abortion facility licenses submitted to this Agency between May 9, 2017 and June 26, 2017.

Kind Regards,

ANGELA L. BECKER
Litigation Liaison & Public Records Coordinator
Office of Legal Affairs
Indiana State Department of Health
317.232.3119 office
317.234.6278 fax
abecker2@isdh.in.gov
www.StateHealth.in.gov



Confidentiality Statement:

This message and any attachments may be confidential. If you are not the intended recipient, please 1) notify me immediately; 2) do not forward the message or attachment; 3) do not print the message or attachment; and 4) erase the message and attachment from your system.

From: Cathie Humbarger [<mailto:cathie.humbarger@ichooselife.org>]
Sent: Sunday, June 25, 2017 4:21 PM



June 26, 2017

Randall Snyder
Division Director, Acute Care
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Dear Mr. Snyder,

I am requesting copies of all applications for abortion facility licenses submitted to the Indiana State Department of Health between May 9, 2017 and June 26, 2017. Please send to the address below or e-mail to cathie.humbarger@ichooselife.org.

Please let me know of any cost related to this request and I will remit payment immediately.

Mail to:
Cathie Humbarger, VP
Indiana Right to Life
2126 Inwood Drive
Fort Wayne, IN 46815

Sincerely,

A handwritten signature in black ink that reads "Cathie Humbarger".

Vice President of Policy Enforcement
Indiana Right to Life



APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R3 / 3-14)
Approved by State Board of Accounts, 2014
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

RECEIVED
JUN 09 2017

Division of Acute Care Use Only

Date Received (mm/dd/yyyy) _____ Date Approved (mm/dd/yyyy) _____ Date Rejected (mm/dd/yyyy) _____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application (Check appropriate item.)

☐ New Facility ☒ Renewal

☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic

Clinic For Women

Street Address (number and street)

3407 West 16th St. 2B

P.O. Box

City

Indpls, IN

County

Marion

ZIP Code +4

46222

Telephone Number

(317)
955-2641

Fax Number

(317)
955-2687

Abortion Clinic e-mail address: cfw@clinic4women.net

Internet Web Address: www.clinic4women.net

B. Mailing Address (if different from abortion clinic location)

Street Address (number and street)

P.O. Box

City

County

ZIP Code +4

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state

Counseling of Indiana

Street Address (number and street)

3607 West 16th Street

P.O. Box

City

Indianapolis

State

Indiana

ZIP Code+4

46222

Telephone Number

(317) 955-2641

Fax Number

(317) 955-2687

EIN Number

351391710

Fiscal Year End Date (mm/dd)

12-31

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s), 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: ☒ Laboratory: CLIA Certificate Number 15D0894576 ☐ Radiology ☒ Counseling
☐ Family Planning ☒ Pharmacy ☐ Other (List): _____

2. Surgical Services: ☐ Gynecology ☒ Other (List): Abortion Services

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: ☒ Registered Nurses: ☐ Licensed Practical Nurses: ☐ 1
Licensed Social Workers: ☐ Other (List title and number): 1- Receptionist
4- Surg. Assistants
1- Lab Tech
2- Med. Assistants
3- Pt. Educators
2- Specimen Techs

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic ☒ Moderate/Conscious Sedation ☐

F. Type of Entity:

For Profit

- ☐ Individual
☐ Partnership
☒ Corporation
☐ Limited Liability Company
☐ Sole Proprietorship
☐ Other (specify) _____

Non-Profit

- ☐ Church Related
☐ Individual
☐ Partnership
☐ Corporation
☐ Limited Liability Company
☐ Other (specify) _____

Government

- ☐ State
☐ County
☐ City
☐ City/County
☐ Hospital District
☐ Federal
☐ Other (specify) _____

G. Officers (if the business entity is incorporated)

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	La Donna Prince	7005 Normandy Way Indpls, IN 46278
Vice-President/Vice-Chairperson/COO	Sally Boone	1547 Preston Way Carmel, IN 46098
Treasurer/CFO	Melissa Baker	2278 E. 40th St Indpls, IN 46203
Secretary	Linda Williams	3940 Basque Ct Indpls, IN 46228

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (Use additional sheet if necessary.)

Name	Business Address/City/State/ZIP	EIN Number
La Donna Prince	3607 W. 16th St Indpls, IN 46222	351391716
Dennis Mickle	3607 W. 16th St. Indpls, IN 46222	351391716

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:

Printed Name and Title:

Date of Signature (mm/dd/yyyy):

Signature of the Clinic Administrator:

Printed Name and Title:

Date of Signature (mm/dd/yyyy):

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	\$500.00
	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).***
- 2. Any supporting attachments.***
- 3. For each physician performing procedures, either:***
 - (A) A copy (in writing) of the physician's admitting privileges; or***
 - (B) A copy of:***
 - (1) his/her written agreement with another physician with admitting privileges; and***
 - (2) a copy (in writing) of that physician's admitting privileges.***
- 4. Payment made payable to "Indiana State Department of Health."***

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236



**APPLICATION FOR LICENSE
TO OPERATE AN ABORTION CLINIC**

State Form 52233 (R3 / 3-14)

Approved by State Board of Accounts, 2014

Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

RECEIVED
JUN 15 2017

Division of Acute Care Use Only

Date Received (mm/dd/yyyy) _____ Date Approved (mm/dd/yyyy) _____ Date Rejected (mm/dd/yyyy) _____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application (Check appropriate item.)

☐ New Facility ☒ Renewal

☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic

Planned Parenthood of Indiana and Kentucky - Bloomington

Street Address (number and street)

421 S. College Ave

P.O. Box

City

Bloomington

County

Monroe

ZIP Code +4

47403

Telephone Number

(812)

336-

0219

Fax Number

(812)

336-

2401

Abortion Clinic e-mail address: laura.miller@ppink.org

Internet Web Address: www.ppink.org

B. Mailing Address (if different from abortion clinic location)

Street Address (number and street)

200 S. Meridian St., Suite 400

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46225

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state

Planned Parenthood of Indiana and Kentucky, Inc.

Street Address (number and street)

200 S. Meridian St. Suite 400

P.O. Box

City

Indianapolis

State

IN

ZIP Code+4

46225

Telephone Number

317.637-4343

Fax Number

317.637-4344

EIN Number

35-0874276

Fiscal Year End Date (mm/dd)

06/30

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s), 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: ☒ Laboratory: CLIA Certificate Number 15D0360690 ☐ Radiology ☐ Counseling
☒ Family Planning ☐ Pharmacy ☐ Other (List): _____

2. Surgical Services: ☒ Gynecology ☐ Other (List): _____

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: ☒ ^{1-APN} Registered Nurses: ☒ Licensed Practical Nurses: ☐

Licensed Social Workers: ☐

Other (List title and number): Health Center Assistants - 6
Health Center Manager - 1

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic ☒

Moderate/Conscious Sedation ☒

F. Type of Entity:

For Profit

- ☐ Individual
☐ Partnership
☐ Corporation
☐ Limited Liability Company
☐ Sole Proprietorship
☐ Other (specify) _____

Non-Profit

- ☐ Church Related
☐ Individual
☐ Partnership
☒ Corporation
☐ Limited Liability Company
☐ Other (specify) _____

Government

- ☐ State
☐ County
☐ City
☐ City/County
☐ Hospital District
☐ Federal
☐ Other (specify) _____

G. Officers (if the business entity is incorporated)

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Kim Green	200 S. Meridian St. Suite 400
Vice-President/Vice-Chairperson/COO	Michael Carter	Indianapolis, IN 46225
Treasurer/CFO	Nathan Ringham	
Secretary	Christie Moore	

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (Use additional sheet if necessary.)

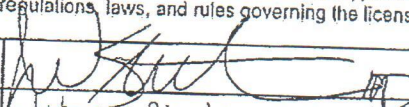
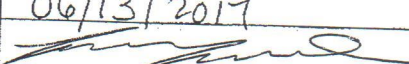
Name	Business Address/City/State/ZIP	EIN Number

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	John Stutsman, Medical Director
Date of Signature (mm/dd/yyyy):	06/13/2017
Signature of the Clinic Administrator:	
Printed Name and Title:	Laura Miller Center Manager
Date of Signature (mm/dd/yyyy):	6/13/17

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
<input checked="" type="checkbox"/>	Zero to 799	\$500.00
<input type="checkbox"/>	800 to 3,499	\$1,000.00
<input type="checkbox"/>	3,500 to 6,999	\$2,000.00
<input type="checkbox"/>	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).*
- 2. Any supporting attachments.*
- 3. For each physician performing procedures, either:*
 - (A) A copy (in writing) of the physician's admitting privileges; or*
 - (B) A copy of:*
 - (1) his/her written agreement with another physician with admitting privileges; and*
 - (2) a copy (in writing) of that physician's admitting privileges.*
- 4. Payment made payable to "Indiana State Department of Health."*

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236



**APPLICATION FOR LICENSE
TO OPERATE AN ABORTION CLINIC**

State Form 52233 (R3 / 3-14)

Approved by State Board of Accounts, 2014

Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

RECEIVED
JUN 15 2017

Division of Acute Care Use Only

Date Received (mm/dd/yyyy) _____ Date Approved (mm/dd/yyyy) _____ Date Rejected (mm/dd/yyyy) _____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application (Check appropriate item.)

☐ New Facility ☒ Renewal

☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic

Planned Parenthood of Indiana and Kentucky - Indianapolis

Street Address (number and street)

8590 Georgetown Road

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46268

Telephone Number

(317)
872-
3115

Fax Number

(317)
872-
3188

Abortion Clinic e-mail address: jennifer.hederington@ppink.org

Internet Web Address: www.ppink.org

B. Mailing Address (if different from abortion clinic location)

Street Address (number and street)

200 S. Meridian St., Suite 400

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46225

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state

Planned Parenthood of Indiana and Kentucky, Inc.

Street Address (number and street)

200 S. Meridian St. Suite 400

P.O. Box

City

Indianapolis

State

IN

ZIP Code+4

46225

Telephone Number

(317) 437-4343

Fax Number

(317) 437-4344

EIN Number

35-0874276

Fiscal Year End Date (mm/dd)

06/30

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: ☒ Laboratory: CLIA Certificate Number 15D0360690 ☐ Radiology ☐ Counseling
☒ Family Planning ☐ Pharmacy ☐ Other (List): _____

2. Surgical Services: ☒ Gynecology ☐ Other (List): _____

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing: Physicians: ☒ 1-APN Registered Nurses: ☒ 3 Licensed Practical Nurses: ☐ 0

Licensed Social Workers: ☐ 0

Other (List title and number): Health Center Assistants - 7
Health Center Manager - 1

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic ☒ 2

Moderate/Conscious Sedation ☒ 2

F. Type of Entity:

For Profit

- ☐ Individual
☐ Partnership
☐ Corporation
☐ Limited Liability Company
☐ Sole Proprietorship
☐ Other (specify) _____

Non-Profit

- ☐ Church Related
☐ Individual
☐ Partnership
☒ Corporation
☐ Limited Liability Company
☐ Other (specify) _____

Government

- ☐ State
☐ County
☐ City
☐ City/County
☐ Hospital District
☐ Federal
☐ Other (specify) _____

G. Officers (if the business entity is incorporated)

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Kim Green	200 S. Meridian St. Suite 400
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Secretary	Christie Moore	

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Name	Business Address/City/State/ZIP	EIN Number

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2,5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:

Printed Name and Title:

Date of Signature (mm/dd/yyyy):

Signature of the Clinic Administrator:

Printed Name and Title:

Date of Signature (mm/dd/yyyy):

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	\$500.00
<input checked="" type="checkbox"/>	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).
2. Any supporting attachments.
3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
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 - (2) a copy (in writing) of that physician's admitting privileges.
4. Payment made payable to "Indiana State Department of Health."

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CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236



**APPLICATION FOR LICENSE
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Please Type or Print Legibly.

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☐ New Facility ☒ Renewal

☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic

Planned Parenthood of Indiana and Kentucky - Lafayette

Street Address (number and street)

964 Mezzanine Drive

P.O. Box

City

Lafayette

County

Tippecanoe

ZIP Code +4

47905

Telephone Number

(765)

446-

8078

Fax Number

(765)

446-

8160

Abortion Clinic e-mail address: jackie.key@ppink.org

Internet Web Address: www.ppink.org

B. Mailing Address (if different from abortion clinic location)

Street Address (number and street)

200 S. Meridian St., Suite 400

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46225

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state

Planned Parenthood of Indiana and Kentucky, Inc.

Street Address (number and street)

200 S. Meridian St. Suite 400

P.O. Box

City

Indianapolis

State

IN

ZIP Code+4

46225

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EIN Number

35-0874276

Fiscal Year End Date (mm/dd)

06/30

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☒ Family Planning ☐ Pharmacy ☐ Other (List): _____

2. Surgical Services: ☒ Gynecology ☐ Other (List): _____

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3. Staffing : Physicians: ☒ ^{APN} Registered Nurses: ☒ Licensed Practical Nurses: ☐
Licensed Social Workers: ☐ Other (List title and number): Health Center Assistants - 3
Health Center Manager - 1

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic ☐ Moderate/Conscious Sedation ☐

F. Type of Entity:

For Profit

- ☐ Individual
☐ Partnership
☐ Corporation
☐ Limited Liability Company
☐ Sole Proprietorship
☐ Other (specify) _____

Non-Profit

- ☐ Church Related
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☐ Hospital District
☐ Federal
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I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:

Printed Name and Title:

Date of Signature (mm/dd/yyyy):

Signature of the Clinic Administrator:

Printed Name and Title:

Date of Signature (mm/dd/yyyy):

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
<input checked="" type="checkbox"/>	Zero to 799	\$500.00
<input type="checkbox"/>	800 to 3,499	\$1,000.00
<input type="checkbox"/>	3,500 to 6,999	\$2,000.00
<input type="checkbox"/>	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

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 - (B) A copy of:*
 - (1) his/her written agreement with another physician with admitting privileges; and*
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- 4. Payment made payable to "Indiana State Department of Health."*

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INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236



**APPLICATION FOR LICENSE
TO OPERATE AN ABORTION CLINIC**

State Form 52233 (R3 / 3-14)
Approved by State Board of Accounts, 2014
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

RECEIVED
JUN 15 2017

Division of Acute Care Use Only

Date Received (mm/dd/yyyy) _____ Date Approved (mm/dd/yyyy) _____ Date Rejected (mm/dd/yyyy) _____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application (Check appropriate item.)

☐ New Facility ☒ Renewal

☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic

Planned Parenthood of Indiana and Kentucky - Merrillville

Street Address (number and street)

8645 Connecticut Street

P.O. Box

City

Merrillville

County

Lake

ZIP Code +4

46410

Telephone Number

(219)
769-
3500

Fax Number

(219)
791-
0538

Abortion Clinic e-mail address: jessica.stienbarger@ppink.org

Internet Web Address: www.ppink.org

B. Mailing Address (if different from abortion clinic location)

Street Address (number and street)

200 S. Meridian St., Suite 400

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46225

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state

Planned Parenthood of Indiana and Kentucky, Inc.

Street Address (number and street)

200 S. Meridian St. Suite 400

P.O. Box

City

Indianapolis

State

IN

ZIP Code+4

46225

Telephone Number

317.637-4343

Fax Number

317.637-4344

EIN Number

35-0874276

Fiscal Year End Date (mm/dd)

06/30

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: ☒ Laboratory: CLIA Certificate Number 15D0360690 ☐ Radiology ☐ Counseling
☒ Family Planning ☐ Pharmacy ☐ Other (List): _____

2. Surgical Services: ☒ Gynecology ☐ Other (List): _____

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: ☒ ^{APN} Registered Nurses: ☒ Licensed Practical Nurses: ☒

Licensed Social Workers: ☐

Other (List title and number): Health Center Assistants - 6
Health Center Manager - 1

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic ☒

Moderate/Conscious Sedation ☐

F. Type of Entity:

For Profit

- ☐ Individual
☐ Partnership
☐ Corporation
☐ Limited Liability Company
☐ Sole Proprietorship
☐ Other (specify) _____

Non-Profit

- ☐ Church Related
☐ Individual
☐ Partnership
☒ Corporation
☐ Limited Liability Company
☐ Other (specify) _____

Government

- ☐ State
☐ County
☐ City
☐ City/County
☐ Hospital District
☐ Federal
☐ Other (specify) _____

G. Officers (if the business entity is incorporated)

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Kim Green	200 S. Meridian St. Suite 400
Vice-President/Vice-Chairperson/COO	Michael Carter	Indianapolis, IN 46225
Treasurer/CFO	Nathan Ringham	
Secretary	Christie Moore	

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (Use additional sheet if necessary.)

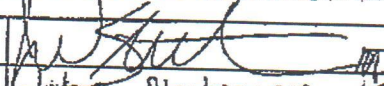
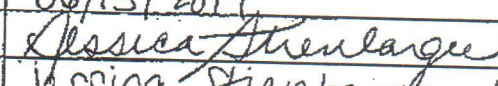
Name	Business Address/City/State/ZIP	EIN Number

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	John Stutsman, Medical Director
Date of Signature (mm/dd/yyyy):	06/13/2017
Signature of the Clinic Administrator:	
Printed Name and Title:	Jessica Stienbarger, Health Center Manager
Date of Signature (mm/dd/yyyy):	10/13/17

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	\$500.00
✓	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).
2. Any supporting attachments.
3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges.
4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236



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SECTION I - TYPE OF APPLICATION

Application (Check appropriate item.)

☐ New Facility ☒ Renewal ☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic

Women's Med Group Professional Corporation

Street Address (number and street)

1201 N Arlington Ave

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46219

Telephone Number

(317)
353 9371

Fax Number

(317)
322-3358

Abortion Clinic e-mail address: martyh@fortemgt.com

Internet Web Address: www.womensmed.com

B. Mailing Address (if different from abortion clinic location)

Street Address (number and street)

P.O. Box

43100

City

Cincinnati, OH

County

Hamilton (OH)

ZIP Code +4

45243

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state

Women's Med Group Professional Corporation

Street Address (number and street)

P.O. Box

43100

City

Cincinnati

State

OH

ZIP Code+4

45243-0100

Telephone Number

(513) 272 0002

Fax Number

(513) 272 0052

EIN Number

31-1148155

Fiscal Year End Date (mm/dd)

12/31

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2.

1. Ancillary Services: ☒ 3 Laboratory: CLIA Certificate Number 15D353797 ☒ 1 Radiology ☒ 1 Counseling
☒ 1 Family Planning ☒ 1 Pharmacy ☐ Other (List): _____

2. Surgical Services: ☒ 1 Gynecology ☐ Other (List): _____

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: ☒ 2 Registered Nurses: ☒ 1 Licensed Practical Nurses: ☒ 0
Licensed Social Workers: ☒ 0 Other (List title and number): _____

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic ☒ 2 Moderate/Conscious Sedation ☒ 0

F. Type of Entity:

For Profit

- ☐ Individual
☐ Partnership
☒ Corporation
☐ Limited Liability Company
☐ Sole Proprietorship
☐ Other (specify) _____

Non-Profit

- ☐ Church Related
☐ Individual
☐ Partnership
☐ Corporation
☐ Limited Liability Company
☐ Other (specify) _____

Government

- ☐ State
☐ County
☐ City
☐ City/County
☐ Hospital District
☐ Federal
☐ Other (specify) _____

G. Officers (if the business entity is incorporated)

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	W Martin Haskell, MD	PO Box 43100 Cincinnati, OH 45243
Vice-President/Vice-Chairperson/COO		
Treasurer/CFO	Valerie Haskell	PO Box 43100 Cincinnati, OH 45243
Secretary	Valerie Haskell	PO Box 43100 Cincinnati, OH 45243

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (Use additional sheet if necessary.)

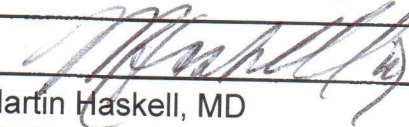
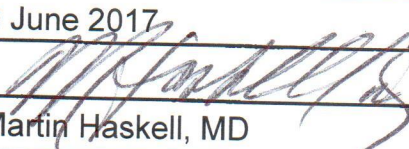
Name	Business Address/City/State/ZIP	EIN Number
W Martin Haskell, MD	PO Box 43100, Cincinnati, OH 45243	

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Martin Haskell, MD
Date of Signature (mm/dd/yyyy):	6 June 2017
Signature of the Clinic Administrator:	
Printed Name and Title:	Martin Haskell, MD
Date of Signature (mm/dd/yyyy):	6 June 2017

See the following page for instructions regarding licensure fees and submission of this application.